Department of LABOR AND INDUSTRIES

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# PROVIDER BULLETIN

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## THIS ISSUE

Outside of Washington State Provider Reimbursement Policies

**TO:**

Providers Outside of Washington State
Self-Insured Employers

**CONTACTS:**

**Provider Hotline**
1-800-848-0811 in US & Canada
360-902-6500 from Olympia and countries outside of the US & Canada

**Evonne Peryea**
(360) 902-6828
(360) 902-4249 FAX

## Purpose

This bulletin summarizes the department's new reimbursement policies for provider's practicing outside Washington State (out-of-state providers). This bulletin also explains how non-Washington providers must reapply using the new provider application/agreement form to continue to be paid for services provided to Washington injured workers.

**The department's out-of-state payment policy and reimbursement changes are effective for dates of service on or after July 1, 2000.**

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# I. Background

### What's changing?

The department is changing its reimbursement policies for non-Washington providers. Effective July 1, 2000, all health care providers, *regardless of their geographic location*, will be paid according to the fee schedule rates and payment policies published in the Washington State *Medical Aid Rules and Fee Schedules* and/or Provider Bulletins.

The department's payments are the sole reimbursements for services related to a Washington worker's industrial insurance claim. Providers may not charge a worker for the difference between the fee schedule maximum or contracted fee and their usual and customary charge.

### What do out-of-state providers need to do?

These reimbursement policy changes require that all non-Washington providers submit a new application/agreement form to continue to be paid by the department for services provided to Washington injured workers on or after July 1, 2000.

### Do these changes affect self-insured employers?

This Provider Bulletin pertains to State Fund and Self-Insured employers. All Self-insured employers must follow the department's maximum fee schedule, medical payment and coverage policies for all services and supplies covered under the Washington State Industrial Insurance Program.

However, self-insured companies who have entered into contracts with non-Washington health care providers may continue their contracts.

### Why is the department changing how it pays non-Washington providers?

The department completed a comprehensive independent study in 1999 regarding how it reimburses providers outside of Washington State. The department explored several of the recommended options in a formal analysis (Decision Paper) in August 1999 and concluded that the appropriate option would be to reimburse all health care providers according to the fee schedule rates and payment policies published in the Washington State *Medical Aid Rules and Fee Schedules* and/or Provider Bulletins. The primary reasons for the changes are to provide equity between Washington State health care providers and out-of-state providers. The proposed changes clarify the department's coverage and payment policies, as well as its reimbursement methodology so that all providers are treated equally regardless of geographic location. The new policies and payment structures outlined in this Provider Bulletin are a result of that analysis.

# II. Provider Application/Agreement

The department has updated its provider application/agreement form. All non-Washington providers are required to submit a new provider application and agreement form to remain an active provider with the department or to reactivate an inactive account.

**Out of state providers will not be paid for dates of service billed on or after July 1, 2000 until a new provider application/agreement has been completed and accepted by the department.**

Refer to Washington Administrative Code (WAC) 296-20-12401 (attached) for more information about the provider application/agreement process.

### How can a provider obtain a new provider application/agreement form?

You can request that a provider agreement/application form be sent by contacting the department's Provider Accounts Section at 360-902-5140, or writing the department at the following address:

Department of Labor and Industries
Attn: Out-of-state Provider Application Request
PO Box 44261
Olympia, WA 98504-4261

Most department forms and publications, including the provider agreement/application, are available on the department's Internet website at: *www.wa.gov/lni/hsa/forms.htm*

### Does having an active provider account with the department guarantee payment of all services?

**No.** An active provider account with the department is not a guarantee of payment for all services. Factors that are considered include, but are not limited to:

1) Is the claim open? Is the condition being treated an accepted condition on the claim?
2) If required by department rules, was the service or surgery preauthorized?
3) Is the service covered by the Industrial Insurance program? (e.g., acupuncture is a **non-covered** service and is not payable.)
4) Is the condition pre-existing, unrelated or not accepted by the department or self-insurer?

The following WACs explain services and equipment the department does and does not cover:

- WAC 296-20-030 for services that are covered.
- WAC 296-20-02700 through WAC 296-20-02705 department process for making medical coverage decisions.
- WAC 296-20-03001 services that require prior authorization.
- WAC 296-20-02850 exceptions for non-covered services.
- WAC 296-20-03002 **non-covered** treatment services.
- WAC 296-20-03010 through WAC 296-20-03024 drug coverage rules.
- WAC 296-20-1102 for devices/equipment.

You can find the WACs listed above in the department's *Medical Aid rules and Fee Schedules* and on the Internet at: *www.wa.gov/lni/home/wacs.htm*

### Where can providers get information about billing electronically?

You can contact the department's Electronic Billing Unit at 360-902-6511 or 360-902-6512.

## III. Out-of-State Reimbursement Rates

Effective July 1, 2000, all health care providers, *regardless of their geographic location*, will be paid according to the fee schedule rates and payment policies published in the Washington State *Medical Aid Rules and Fee Schedules* and/or Provider Bulletins. See the summary table below:

### Fee Schedule for Professional Services and Hospital Services

| | | |
|---|---|---|
| ***Non-hospital based services: Professional Services, Radiology, Laboratory, Pathology, Ambulance Services, and Physical Therapy services; Hospital Inpatient Professional services: Evaluation & Management*** | Reimbursement rates: These services will be paid using the fee schedule rates and payment policies stated in the Washington *Medical Aid Rules and Fee Schedules*.<br><br>Billing Forms: Bill professional and ambulance services with CPT and HCPCS codes on HCFA 1500 forms under separate provider numbers. | Bill military and Veteran's Administration professional and ambulance services on HCFA 1500 forms. Their reimbursement will be at 100% of allowed charges. |

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| ***Hospital Outpatient Services*** | Reimbursement rate:These services will be paid at the out-of-state percent of allowed charges (POAC) factor* as stated in the Washington *Medical Aid Rules and Fee Schedules*.<br><br>Billing Forms: Bill all hospital outpatient services with revenue, CPT, HCPCS codes on UB92 (HCFA 1450) forms under the hospital provider number. | Military, Veteran's Administration, health maintenance organization, children's, and state run psychiatric hospitals will be paid at 100% of allowed charges for outpatient hospital services. |

| | | |
|---|---|---|
| ***Hospital Inpatient Services*** | Reimbursement rate:These services will be paid at the out-of-state percent of allowed charges (POAC) factor* as stated in the Washington *Medical Aid Rules and Fee Schedules.*<br><br>Billing Forms: Bill all hospital inpatient services using revenue codes on UB92 (HCFA1450) forms under the hospital provider number. | Military, Veteran's Administration, health maintenance organization, children's, and state run psychiatric hospitals will be paid at 100% of allowed charges for inpatient hospital services. |

***Effective 7/1/00 the non-Washington Hospital POAC factor is 0.654. This POAC factor is equal to the Washington Statewide average POAC for hospitals.**

### The following WACs will help you locate detailed information regarding reimbursement to non-Washington providers for hospital services:

1) WAC 296-20-022 and WAC 296-23A-0230: How all health care providers outside of Washington State will be paid for medical and hospital inpatient/outpatient services.
2) WAC 296-23A-0230: How the department calculates the Percentage of Allowed Charge (POAC) for hospitals located outside of Washington State.

### Where can providers locate fees for specific CPT, HCPCS and local codes?

See the department's fee schedule located in the back of the Medical Aid Rules and Fee Schedules. If you need a copy of this publication, contact the Provider Hotline listed on the front of this bulletin.

### Pharmacy Fee Schedule

On November 1, 1999 the department adopted a new pharmacy fee schedule for in-state pharmacies. **Effective July 1, 2000 this fee schedule will be adopted as the department's reimbursement policy for all non-Washington pharmacies.**

Payment for drugs and medications including all oral nonlegend drugs will be made on the following basis:

| | |
|---|---|
| Generic | **The lesser of BaseLine Price™ (BLP) or Average Wholesale Price (AWP) less 10%**<br>**+**<br>$4.50 Professional Fee |
| **Brand with Generic Equivalent**<br>(Substitution Allowed) | **The lesser of BLP or AWP less 10%**<br>+<br>$3.00 Professional Fee |
| **Brand with Generic Equivalent**<br>(Dispensed as Written) | **AWP less 10%**<br>+<br>$4.50 Professional Fee |
| Single or multi-source Brand name drugs | **AWP less 10%**<br>+<br>$4.50 Professional Fee |

Compounded prescriptions will be paid at the allowed cost of the ingredients, a compounding time fee of $4.00 per 15 minutes plus the applicable professional component as indicated above.

Per RCW 82.08.0281 prescription drugs and oral or topical over-the-counter medications are nontaxable.

The new fee schedule will affect all prescriptions filled on or after July 1, 2000. Prescriptions filled prior to this will be paid under the old fee schedule. The new pharmacy fee schedule will be listed in the

Specialty Providers and Local Codes section of the department's *Medical Aid Rules & Fee Schedules* when it is published on July 1, 2000.

### What fee should a pharmacy provider bill the department?

"All fees listed are the maximum fees allowable. Practitioners shall bill their usual and customary fee for services. If a usual and customary fee for any particular service is lower to the general public than listed in the fee schedules, the practitioner shall bill the department or self-insurer at the lower rate." WAC 296-20-010 General information, section (2).

### What is the department's policy regarding "Generic Formulary" and pricing?

"Approved generics are to be substituted for brand name pharmaceuticals in all cases unless the worker's condition will not tolerate a generic preparation and the prescribing physician indicates no substitution is permitted." For further detail see:WAC 296-20-17001, Allowance and payment for medication.

## IV. Tens Unit Billing Procedures

### What is the department's authorization and payment policy regarding TENS Units (Transcutaneous Electrical Nerve Stimulator)?

TENS units and supplies for State Fund injured workers are provided under contract. All providers who prescribe TENS units for State Fund injured workers must use the department's contracted vendor.

All providers must receive preauthorization from the department in order to provide a TENS unit for an Injured worker per WAC 296-20-03001.

For details on how the department pays for TENS units refer to Provider Bulletin 97-01. You may obtain this bulletin by calling the department's toll free line at 1-800-848-0811.

## V. Authorization and Payment Policies for Medical and Hospital Services

### How is a claim initiated?

When the worker or the attending physician determines that an injury or condition may be industrial in nature the treating doctor must file, a Report of Accident form per WAC 296-20-025.

### Who can sign the Report of Accident form?

Only licensed Medical Doctors, Osteopathic Physicians, Chiropractors, and other providers listed in WAC 296-20-01002 "Definitions' section" entitled Doctor, can sign an accident report.

### What services require prior authorization?

**PRIOR AUTHORIZATION MUST BE OBTAINED** from the department or self-insurer for all services and devices**,** in accordance with WAC 296-20-03001, WAC 296-20-1101, and as outlined in department policy.

### What fee should a provider bill the department or self-insurer?

Providers must bill their **usual and customary** fee when treating injured workers. (Per WAC 296-20-010, Section 2.)

The insurer will pay the provider's usual and customary fee, or fee schedule maximum, or contracted rate, whichever amount is less.

### Can the injured worker be billed for services that are for the accepted industrial injury or disease?

A supplier or provider may **not** charge a worker the difference between the fee schedule maximum or contracted fee and their usual and customary charge. (Per WAC 296-23-165, section 1a.) The amount paid by the department is the full amount that can be collected for the services provided.

### What billing forms should providers use?

**The department's "General Provider Billing Manual" describes the various types of billing forms a provider or supplier of services and goods needs to bill.** Below is a brief summation of some of the major provider types/services and the forms that should be used to bill the department.

For further details, please refer to the department's "**General Provider Billing Manual."** (Form #F248-100-000) Providers receive this manual when they are assigned a provider number by the department. If you wish to receive a copy please call the department's Provider Accounts Unit at 360-902-5140.

### What is the department's policy regarding payment of supply codes?

Supply codes that do not have a fee listed will be reimbursed at their **acquisition cost**.

Invoices for all supplies must be retained in provider records and copies of invoices must be submitted with a bill for individual supplies costing $150.00 or more.

- **Exception: DME providers will be reimbursed based on billed charges, which are subject to review, per department policy.**

- **Exception: Electronic billers should submit supply receipts within 5 days of bill submission. Submit copies to: Dept. of Labor and Industries, P.O. Box 44291, Olympia, WA. 98504-4291.**

## VI. Documentation And Record Keeping Requirements

### How long must a provider keep records on an injured worker?

Per WAC 296-20-02005 "Keeping of Records," providers are required to keep all records necessary for the department to audit the provision of services for a **minimum of five years**.

Providers can find the department's general reporting requirements in WAC 296-20-06101. Documents required for billing purposes are also listed under WAC 296-20-125, Billing Procedures, section 6(a-h).

## VII. Independent Medical Examinations (IMEs)

The following WACs help explain the department's rules regarding IMEs.

| | |
|---|---|
| WAC 296-23-255 | IMEs |
| WAC 296-23-260 | Examination reports |
| WAC 296-23-265 | Independent medical examinations examiner |
| WAC 296-23-270 | Independent medical examinations two or more examiners |
| WAC 296-14-300 | Mental condition/mental disabilities |
| WAC 296-20-200 | Category Rating System for IMEs |
| WAC 296-20-210 | General Rules |
| WAC 296-20-220 | Special rules for evaluation of permanent bodily impairment |

For further WAC rules and procedure code information on IMEs a copy of the Department's ***Medical Examiner's Handbook*** may be ordered by calling the department's Provider Hotline at: 1-800-848-0811.

## Attachment

## WAC 296-20-12401 Provider application process

### (1) How can a provider obtain a provider account number from the department?

In order to receive a provider account number from the department, a provider must:

- Complete a provider application
- Sign a provider agreement,
- Provide a copy of any practice or other license held,
- Complete, sign and return a Form W-9,and
- Meet the department's provider eligibility requirements as cited in the department's rules.

NOTES: A provider account number is required to receive payment from the department, but is not a guarantee of payment for services. Self-insured employers may have additional requirements for provider status.

### (2) Provider account status definitions:

- Active—account information is current and provider is eligible to receive payment
- Inactive—account is not eligible to receive payment based on action by the department or at provider request. These accounts can be reactivated.
- Terminated— account is not eligible to receive payment based on action by the department or at provider request. These accounts cannot be reactivated.

## When may the department inactivate a provider account?

The department may inactivate a provider account when:

- There has been no billing activity on the account for eighteen (18) months, or
- The provider requests inactivation, or
- Provider communications are returned due to address changes, or
- The department changes the provider application or application procedures, or
- Provider does not comply with department request to update information.

### (3) When may the department terminate a provider account?

The department may terminate a provider account when:

- The provider is found ineligible to treat per department rules, or
- The provider requests termination, or
- The provider dies or is no longer in active business status.

### (4) How can a provider reactivate a provider account?

To reactivate a provider account, the provider may call or write the department. The department may require the provider to update the provider application and/or agreement or complete other needed forms prior to reactivation. Account reactivation is subject to department review.